GUAM BOARD OF NURSE EXAMINERS
Department of Public Health & Social Services
Mailing Address:
123 Chalan Kareta, Mangilao, Guam 96913

NURSING RENEWAL APPLICATION FORM

◯ **CNA** ◯ **LPN** ◯ **RN** ◯ **APRN**

Personal Data		
Last Name	First Name	Middle
Social Security Number:		
Guam License Number:		
Date of Birth:	Place of Birth:	
Previous Name(s):		
Mailing Address:		
Residential Address:		
Telephone Number(s):		
Email Address:		

Professional Data	
Highest Nursing Degree Obtained:	Date Obtained:
Highest Educational Degree:	Date Obtained:
Specialty or Certification in Nursing:	# of Years:

Employment History		
Current Employer:	Address:	Telephone Number:
Position Title/Section:		

Disciplinary History	
Have any licenses been restricted, revoked, suspended, surrendered or denied?	☐ Yes ☑ No
Have you been disciplined or a subject in any disciplinary hearings?	☐ Yes ☑ No
Have you ever resigned or been told to resign from employment to avoid termination?	☐ Yes ☑ No
Were you terminated from employment for any reason?	☐ Yes ☑ No
Any pending complaints, charges against you as related to nursing practice?	☐ Yes ☑ No
History of Drugs or Alcohol Misuse/Abuse/Addictions/Treatments?	☐ Yes ☑ No
Any Criminal Court convictions?	☐ Yes ☑ No
Any allegations of unprofessional unethical conduct?	☐ Yes ☑ No
I am the subject of a medical malpractice liability claim, settlement, judicial or administrative adjudication case pending or otherwise resolved.	☐ Yes ☑ No
Have you been fined for any reason for nursing practice violation?	☐ Yes ☑ No
History of fraud in the procurement of a license or certification?	☐ Yes ☑ No
History of Sexual Crime(s) or are you listed on the Sexual Registry?	☐ Yes ☑ No
History or Present Physical, Mental, Emotional, Behavioral Conditions that may affect nursing practice?	☐ Yes ☑ No
I am delinquent or more than 90 days in child support, spousal support/alimony or payment of an educational loan.	☐ Yes ☑ No
***Supporting Documents and Statements must accompany all "Yes" answers.**	

Certifying Statement:

I certify all information submitted in this application is true and complete to the best of my knowledge and belief and I have the ability to perform within my scope of practice. By virtue of signing this application, I do solemnly swear that I am of good character, free of communicable disease, in good physical and mental health, and I personally completed this form, and the photo is my true likeness.
I authorize the Guam Board of Nurse Examiners, the Health Professional Licensing Office (DPHSS) staff, and their agents to investigate, verify, obtain, release, any and all information provided through personnel files, legal documents, emails, and other forms of communication-written or verbal.
I authorize the release of professional and personal information to individuals, institutions, agencies, and the Data Bank.
I understand and agree that I have the burden of producing adequate information for proper evaluation of my professional competence, personal health, character, ethics, and other qualifications for resolving any doubts of such qualifications.
I understand that knowingly providing false or incomplete information is punishable by fine or imprisonment under United States Code Title 18, Section 1001 and all applicable laws of Guam. If I am a non US Citizen, I will provide supporting documentation showing eligibility to work and lice in the United States and in the Territory of Guam.

Print Name:

Signature:

Date:

Subscribed and sworn to me this _____ day of _____, in this year _____

Notary Public _____

Expiration Date _____

Address/Telephone Number _____

(Affix Seal Here)

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Mangilao, Guam 96913

GUAM NURSING CONTINUING EDUCATION REPORT

Please Type or Print (Use Blue or Black Ink ONLY)

A. IDENTIFICATION: ◯ Mr. ◉ Mrs. ◯ Miss ◯ Ms.

1. Name: _____ Guam Certificate No. _____
   Last First MI
2. Email Address: _____ Telephone No.: _____
3. Current Employer: _____ Position Title: _____

B. CONTINUING NURSING EDUCATION RECORD:

DATE	TOPIC	ORGANIZER'S NAME	HOURS
		Total Number of Hours Reports:	

I understand that my application will not be accepted for processing until it has been completed in its entirety and I hereby affirm and declare that the above information is true and correct and that any fraudulent entry may be considered cause for rejection or subsequent revocation. It is also understood that the Guam Board of Nurse Examiners may conduct an audit of the registration activities reported on these forms at anytime.

_____ _____
Signature Date

[ATTACHMENT FORM C]

GUAM BOARD OF NURSE EXAMINERS

Department of Public Health & Social Services
123 Chalan Kareta
Mangilao, Guam 96913

RECORD OF PAYMENT

I. IDENTIFICATION

NAME: _____
(Last Name) (First Name) (Middle)

MAILING ADDRESS: _____
(Street Address)

_____
(City) (State) (Zip Code)

SIGNATURE: _____ DATE: _____

II. VERIFICATION OF CERTIFICATE:

Please print the complete name used on original certification and your social security number

_____ SS#_____
(Print Full Name)

III. FEE

Fee paid are **NON-REFUNDABLE**. Make all checks or money orders payable to **TREASURER OF GUAM**

$ 100.00	RN EXAM	
$ 100.00	PN EXAM	
$ 100.00	Endorsement	
$ 125.00	Reinstatement for Lapsed or Inactive	
$ 80.00	RN License Renewal	
$ 60.00	LPN License Renewal	
$ 25.00	License Verification	
$ 25.00	Temporary Work Permit (RN, LPN, CNA)	
$ 20.00	Reissuance of License	
$ 400.00	RN of PN Nursing Education Program Approval Fee	
$ 150.00	RN or PN Continuation of Full approval Fee	
$ 150.00	APRN License Application Fee	
$ 150.00	APRN Reinstatement of License	
$ 100.00	APRN License Renewal	
$ 75.00	APRN Temporary Work Permit	
$ 150.00	APRN Prescriptive Authority	
	OTHER	
$ 35.00	Examination Proctoring	
$ 10.00	Nurse Practice Act	
$ 10.00	Rules and Regulations	
$ 50.00	Nurse Assistant Application for Exam	
$ 25.00	Nurse Assistant Endorsement	
$ 40.00	Nurse Assistant Reinstatement	
$ 25.00	Nurse Assistant Certificate Renewal	
$ 25.00	Certification Verification	
$ 20.00	Reissuance of Certificate	
$ 200.00	Nurse Assistant Program Approval Fee	

Present this form with payment to the cashier at the Department of Public Health & Social Services/Treasurer's Office then return the processed form to GBNE.

OFF-ISLAND APPLICANTS: Return this form with your payment to the GBNE at the above address.

FOR OFFICE USE ONLY

Payment: CHECK MONEY ORDER CASH CREDIT CARD

Field Receipt#: _____ Date Paid: _____

DEPOSIT TO ACCOUNT: 324156344